

A Vision for Minority Health and Health Disparities Research

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NIH National Institute
on Minority Health
and Health Disparities

NIMHD History

1990

Established as an Office under the NIH Director through DHHS Secretary Louis W. Sullivan, M.D. in 1990

2000

Transitioned to a Center through legislation championed by Representative Louis Stokes (D-OH) in 2000

2010

Patient Protection and Affordable Care Act contained language championed by Senator Ben Cardin (D-MD) to transition to an Institute in 2010

2014

John Ruffin, Ph.D. led all the entities until his retirement in March 2014; Yvonne T. Maddox, Ph.D. became Acting Director

2015

Eliseo J. Pérez-Stable, M.D., started September 1, 2015

2017

FY 2017 budget is \$289 million



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Minority Health Definition

- **Minority Health Research focuses on health determinants that lead to specific outcomes within a minority group and in comparison to others**
- **Race and ethnic minorities share a social disadvantage and/or are subject to discrimination as a common theme**



OMB Race/Ethnic Classification

- **African American or Black**
- **Asian: East, Southeast, South**
- **American Indian or Alaska Native**
- **Native Hawaiian or other Pacific Islander (not Asian)**
- **Latino or Hispanic (20 countries)**
- **White: Europe, Middle East, N Africa**



Health Disparity Populations

- Health disparity populations include:
 - racial/ethnic minorities defined by OMB
 - less privileged socio-economic status
 - underserved rural residents, and/or
 - sexual gender minorities
- Populations have poorer health outcomes often attributed in part to social disadvantage, being subject to discrimination, and underserved in the full spectrum of health care.



Health Disparity Outcomes

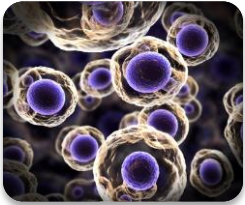
- Higher incidence and/or prevalence
- Burden of disease measured by *Disability-Adjusted Life Years (DALYS)*
- Premature and/or excessive *mortality* in areas where populations differ
- Poorer health-related quality of life and/or daily functioning using standardized measures



Mechanisms Leading to Health Disparities



Individual Behaviors, Lifestyle, Beliefs and Response to chronic Stress: racism, childhood adverse conditions, food insecurity, witness to or victim of violence, immigrant, limited English proficiency



Biological Processes and Genetics: earlier age of onset, gene variants, metabolic differences, susceptibility, faster progression or greater severity, brain networks, microbiome, extracellular RNA



Physical and Cultural Environment: place, social system, neighborhood, infrastructure, family, social interactions, network, community cohesion



Clinical Events and Health Care: differential treatments, poor communication, adverse events to medications, falls, progression of disease, access, use/abuse of appropriate services, end of life care



Health Disparity Populations: Race/Ethnicity, Low SES, Rural, Sexual/Gender Minority

Other Fundamental Characteristics: Sex/Gender, Disability, Geographic Region

Domains of Influence	Levels of Influence			
	Individual	Interpersonal	Community	Societal
Biological	Biological Vulnerability and Mechanisms	Caregiver-Child Interaction Family Microbiome	Community Illness Exposure Herd Immunity	Sanitation Immunization Pathogen exposure
Behavioral	Health Behaviors Coping Strategies	Family Functioning School/Work Functioning	Community Functioning	Policies and Laws
Physical/ Built Environment	Personal Environment	Household Environment School/ Work Environment	Community Environment Community Resources	Societal Structure
Sociocultural Environment	Sociodemographic Limited English Cultural Identity Response to Discrimination	Social Networks Family/Peer Norms Interpersonal Discrimination	Community Norms Local Structural Discrimination	Societal Norms Societal Structural Discrimination
Healthcare System	Insurance Coverage Health Literacy Treatment Preferences	Patient-Clinician Relationship Medical Decision-Making	Availability of Health Services Safety Net Services	Quality of Care Healthcare Policies
Health Outcomes	Individual Health	Family/ Organizational Health	Community Health	Population Health





Inclusion of Diverse Participants

- **All disparity populations are historically underrepresented in biomedical research**
- **Inclusion of minorities in clinical studies is an goal of NIMHD but separate from research**
- **Social justice, good science, and common sense mandate inclusion (40% US population)**
- **In 2014, 26% of participants in NIH-funded clinical studies were minorities; 11% Blacks**





We Have to be at The Table

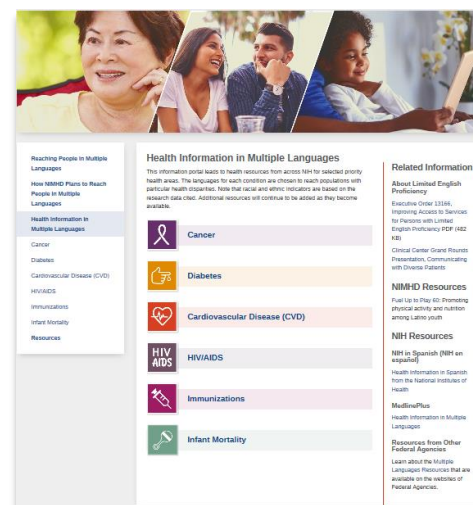
- **Yes, it is harder to recruit minorities and it usually takes more resources and different skills**
- **More face time and personal messages**
- **Minority scientists are generally better at it**
- **We need greater granularity (SES, birthplace, language) and investigator accountability**
- **End myth that barriers are insurmountable**



NIMHD's Language Access Portal

The Language Access Portal (LAP):

- **Purpose:** Improves access to cross-cultural and linguistically appropriate health information.
- **Design:** Consolidates health resources from across NIH and other federal agencies that are available in select languages for populations experiencing significant health disparities.
- **Audience:** NIMHD research community, public and community health professionals, clinicians, and others working with limited English proficient (LEP) populations
- **Rationale:** provide meaningful access to services and information for persons with LEP



Visit <https://www.nimhd.nih.gov/programs/education/language-access/>



Diversity in Science and Medicine is a Demographic Mandate

- **Develop a diverse clinical workforce that will care for our patients**
- **Medical school graduates in 2014: 5% Latino, 6% African American, <1% American Indian**
- **Develop a diverse biomedical scientific workforce that will conduct research in all areas of science**
- **About 7% of all NIH R01 grants are awarded to African American and Latino PIs; apparent bias in funding Blacks**



Fostering the Next Generation of Researchers

2017 Health Disparities Research Institute

August 14 - 18, 2017



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Musculoskeletal and Arthritis Disorders in Minority Health and Health Disparities

- **Systemic Lupus: all minorities with increased risk and severity**
- **SLE and renal disease leads to worse outcomes in Blacks**
- **Scleroderma: AI/AN**
- **Osteoarthritis: More disability and quality of life impact on Blacks**
- **Rheumatoid Arthritis: African Am, Latinos, Asian, poor**



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Dermatological Clinical Issues in Minority Health and Health Disparities

- **Chronic pruritus: 6000 Veterans surveyed about quality of life**
- **Non-Whites had more burning, scarring emotional impact, and primary care visits**
- **Atopic dermatitis: African Am**
- **Vitiligo: Dark skin persons**



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Arthritis-Attributable Activity Limitation

National Health Interview Survey, 2013-2015

	% Sample	Prevalence
White	76.0	40.1
Black	11.2	48.6
Asian	2.7	37.6
American Indian/AN	0.6	51.6
Latino	8.1	44.3

Educational Level	% Sample	Prevalence
< High School	15.1	52.1
High School / GED	28.5	43.1
Some College / Tech	31.1	43.6
College Graduate	25.4	32.1

MMWR, March 10, 2017: 66: 246-2538



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Policy Strategies to Reduce Health Care Disparities

- **Expand Access: Health insurance, place and clinician as fundamental**
- **Public Health Consensus**
- **Coordination of Care: Systems, navigators, and target conditions**
- **Patient-Centered: PCMH, effective communication, cultural competence**
- **Performance measurement: Risk**



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Perception of Unfair Treatment: 2015

In past 30 days were you treated unfairly because of racial or ethnic background in store, work, entertainment place, dealing with police, or getting healthcare?	Percent agree
Latinos	36% / 14%
African Americans	53% / 12%
Whites	15% / 5%

Kaiser Family Foundation Survey of Americans on Race, November 2015.



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Community Engaged Research to Reduce Health Disparities: What is Needed?

- **Shift models of care to population health with accurate demographic and social determinants of health**
- **Enhance access to health care services: portal for patients, e-referrals, tele-medicine**
- **Address access to real food and safe places**
- **Engage community resources in promoting health: nutrition, physical space, tobacco**
- **Recognize and manage discrimination**



Precision Medicine and Clinical Care

- **When is “more precise” individualized approach better than a standard one with demonstrated efficacy?**
- **One size fits all approach can work to improve outcomes in many clinical situations**
- **New is not always better and is usually more expensive — cost has to be considered**
- **Precision in patient-clinician interactions**
- **Enhance cultural competence and reduce structural discrimination**



NIMHD Intramural Program

- **Population science emphasis with clinical component**
- **Recruited scientific director who will start in November**
- **Recruit new scientists including a clinician**
- **Propose cohort study**
- **Network with DIR programs with MH/HD interests: NCI, NIA, NIDDK, NICHD, NIEHS, NHLBI, NIAMS**



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